Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
10 YEARS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age (Years)

Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	B.P.	Health Plan Name

TO BE FILLED IN BY PROVIDER

T _____
P _____
R _____

HISTORY INITIAL/INTERVAL
Comments

NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] Referred

SENSORY SCREEN
Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing: Within normal limits? [ ] Yes [ ] No, Refer
Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT **Age appropriate?** [ ] Yes [ ] No
(If suspicious, do specific objective testing) Assessment Tool (name) _____

BEHAVIORAL HEALTH ASSESSMENT **Referral indicated?** [ ] Yes [ ] No
Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine/Neuro		

LAB/SCREENING

Tuberculin Test		
Urinalysis		
Hct./Hgb		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Good health habits and self-care
[ ] Social interactions
[ ] Good parenting practices
[ ] Educational activities
[ ] Sexuality education

REFERRALS

[ ] Dental
[ ] Behavioral Health _____
[ ] CRS
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No